

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012673

STATE FILE NUMBER

FILED MAY 8 1959		Registration District No. 71		Primary Registration District No. 3012		Registrar's No. 39	
1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>				c. CITY OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>512 Elms Blvd.</u>				Length of stay in lb <u>56 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>512 Elms Blvd</u>	
3. NAME OF DECEASED (Type or print) First <u>STONE</u> Middle <u>WALL</u> Last <u>McDAVID</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1876</u>	
9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <u>82</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired partner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Livery Business</u>		11. BIRTHPLACE (City and state or country) <u>Carroll County, Mo.</u>	
13a. FATHER'S NAME <u>Fleming McDawid</u>				13b. MOTHER'S MAIDEN NAME <u>Emerella Cundiff</u>		14. NAME OF HUSBAND OR WIFE <u>Flora Henry McDavid</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Flora McDavid, 512 Elms Blvd., Ex. Spr., Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>arteriosclerosis coronary a.</u> DUE TO (c) <u>arteriosclerosis, Generalized.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis, Generalized.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour <u>1</u> Month <u>4</u> Day <u>19</u> Year <u>1959</u> a.m. p.m.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION		COUNTY		
20g. STATE			20h. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21. I attended the deceased from <u>3-4-54</u> to <u>4-19-59</u> and last saw her alive on <u>4-18-59</u> Death occurred at <u>7:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>David Musgrave M.D.</u>				22b. ADDRESS <u>Excelsior Springs, Mo.</u>		22c. DATE SIGNED <u>4-28-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-21-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u>	
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u>				25. DATE RECD. BY LOCAL REG. <u>4-29-59</u>		26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>	
Excelsior Springs, Missouri (Licensed Embalmer's Statement on Reverse Side)							

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUN 28 1961



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Lindell Jarman*

Licensed Embalmer No. *4589*
Excelsior Springs, Mo.
P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.